North Carolina's Certificate of Need Law in the 21st Century Revisited: What Have We Learned?

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Presented to the House Select Committee on Certificate of Need and Related Hospital Issues

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Outline

- Reasons to retain CON regulation
- Improvements implemented since 2011
- Opportunities for CON law improvement

Reasons to Retain CON Regulation

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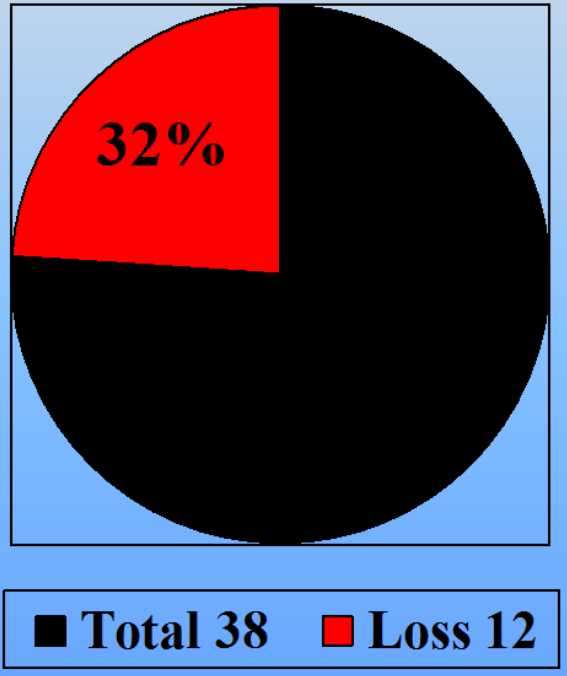
Ensures continued strength and credit-worthiness of North Carolina's health care market

NC Medical Care Commission

Hospitals with Outstanding Debt as of June 2012

Loss from Operations at FYE 2011



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NCDHSR "Financial Condition of Hospitals & CCRCs"
Medical Care Commission Quarterly Meeting, June 30, 2012

OUTSTANDING DEBT

As of June 30, 2012, the Commission has closed 423 revenue bonds, notes and leases. The total authorized principal amount of all such financings was $18,805,396,052 and the total outstanding principal amount of all such financings as of June 30, 2012 was $7,456,353,735 excluding financings that have been refunded.

NC Medical Care Commission
"Health Care Facilities Finance Act Annual Report," June 30, 2012

Health Care providers in these states and geographic regions benefit from a combination of strong demographic and economic trends, favorable payer environments, and the presence of strong Certificate of Need regulation. Two states in particular, Virginia and North Carolina, stand out when comparing their characteristics and hospital ratings to other states in the country.

Moody's Investors Service, 2004

Reasons to retain CON regulation

Regardless of election outcome, health care providers continue to operate under tremendous uncertainty with ACA implications

Cuts Anticipated over Next 10 Years

Programs / Actions Causing Cuts	Statewide 10-Year Impact
Hospital Acquired Conditions	($ 72,265,014)
Value-Based Purchasing	$ 2,985,917*
Readmissions Reduction Program	($ 208,627,000)
ACA / CMS Medicare Payment Reductions	($ 4,593,501,000)
Deficit Reduction Sequestration Requirement (2% Medicare Reduction Resulting from Lack of Super Committee Action)	($ 1,259,248,500)
ACA Medicare DSH Reductions	($ 847,659,000)
Effect of Massachusetts' Manipulation of Medicare "rural floor" wage index calculation (stemming from national budget neutrality)	($ 218,000,000)
Bad Debt Reimbursement Restrictions	($ 125,452,600)
Total Known Cuts (June 19, 2012)	($7,196,314,597)

*Single year impact only. Ten-year projection not possible. Sources: American Hospital Association, DataGen

Transparency & Accountability

Charlotte Observer
April 21, 2012

Reasons to retain CON regulation: Transparency & Accountability

- **CON applicants must report existing and proposed levels of service to charity care recipients, Medicare/Medicaid recipients and bad debt.**
- **Applicants required to provide audited financials which will contain their charity care, bad debt figures and charity care policies.**
- **Access by medically underserved groups (specifically Medicare/Medicaid recipients) is used as a comparative factor in competitive CON reviews.**
- **Applicants must materially comply with the representations in their CON applications.**

Reasons to retain CON regulation: Transparency & Accountability

Example from CON application filed by Forsyth Medical Center in May 2012:

1. **What amount of charity care did the facility provide to patients during the last full fiscal year?**
   $79,663,814 in Charity Care which was 12.48% of net revenue
2. **Does this amount include bad debt?**
   No
   If so, what amount is bad debt?
   $19,294,332 in bad debt, which was 3.02% of net revenue
3. **Provide an estimate of the amount of charity care that will be provided in each of the first two fiscal years of operation for the project.**
   In Project Year 1, $92,379,006 in Charity Care, which is 12.25% of net revenue
   In Project Year 2, $97,053,384 in Charity Care, which is 12.48% of net revenue
4. **Does this amount include bad debt?**
   No
   If so, what amount is bad debt?
   In Project Year 1, $22,373,913 in bad debt, which is 3.02% of net revenue
   In Project Year 2, $23,506,033 in bad debt, which is 3.02% of net revenue

Improvements Implemented Since 2011

Improvements Implemented Since 2011

- **NCHA facilitated agreed-upon clarification of CON exemption for Academic Medical Centers (Policy AC-3)**
- **2012 SMFP includes that Policy AC-3 clarification**
- **Opportunity for statutory action**

CHAPTER 4
STATEMENT OF POLICIES

Summary of Policy Changes for 2012

There is one substantive policy change incorporated into the North Carolina 2012 State Medical Facilities Plan. POLICY AC-3: EXEMPTION FROM PLAN PROVISIONS FOR CERTAIN ACADEMIC MEDICAL CENTER TEACHING HOSPITAL PROJECTS has been revised to clarify the existing language and to strengthen the focus on "…unique academic medical needs."

Throughout Chapter 4, references to dates have been advanced by one year, as appropriate.

POLICIES APPLICABLE TO ACUTE CARE HOSPITALS (AC)

POLICY AC-1: USE OF LICENSED BED CAPACITY DATA FOR PLANNING PURPOSES

For planning purposes, the number of licensed beds shall be determined by the Division of Health Service Regulation in accordance with standards found in 10A NCAC 13B - Section .6200 and Section .3102 (d).

Licensed bed capacity of each hospital is used for planning purposes. It is the hospital's responsibility to notify the Division of Health Service Regulation promptly when any of the space allocated to its licensed bed capacity is converted to another use, including purposes not directly related to health care.

POLICY AC-3: EXEMPTION FROM PLAN PROVISIONS FOR CERTAIN ACADEMIC MEDICAL CENTER TEACHING HOSPITAL PROJECTS

Projects for which certificates of need are sought by academic medical center teaching hospitals may qualify for exemption from the need determinations of this document. The Medical Facilities Planning Branch shall designate as an Academic Medical Center Teaching Hospital any facility whose application for such designation demonstrates the following characteristics of the hospital:

1. Serves as a primary teaching site for a school of medicine and at least one other health professional school, providing undergraduate, graduate and postgraduate education.

2. Houses extensive basic medical science and clinical research programs, patients and equipment.

Improvements Implemented Since 2011

Transparency

There have been several updates to our web site and internal processes.

Certificate of Need (CON)

- Decisions and Findings posted monthly;
- Letters of no review and exemptions posted monthly;
- The monthly report has been broken down from one report into 7 separate reports;
- The seven reports include:
  - Appeals from the previous month
  - Certificates issued in the previous month
  - Decisions during the previous month
  - Expedited review petitions approved in the previous month
  - Reviews extended in the previous month
  - Written comments and public hearings for the upcoming review cycle
  - Application log of the current month

We have the ability to accommodate the uploading of a CD or DVD of a CON application to the website and are in the planning stages for this to begin soon.

State Health Coordinating Council (SHCC)

- Held six public hearings on the Proposed 2013 State Medical Facilities Plan
  - Greensboro, Asheville, Charlotte, Greenville, Wilmington and Raleigh
- Posted revised general information on public hearings to website for each public hearing listing
- Beginning with the summer petitions the petitions and comments page was revised to be more user friendly and for clarity on searching for specific petitions and comments filed

NC DHSR
Update on Activities

as reported to
House Select Committee on CON
September 13, 2012

Opportunities for CON Law Improvement

Opportunities for CON Law Improvement

Reduce delays in provision of needed facilities and services.

Opportunities for CON Law Improvement

Bond requirement inadequate to deter frivolous appeals.

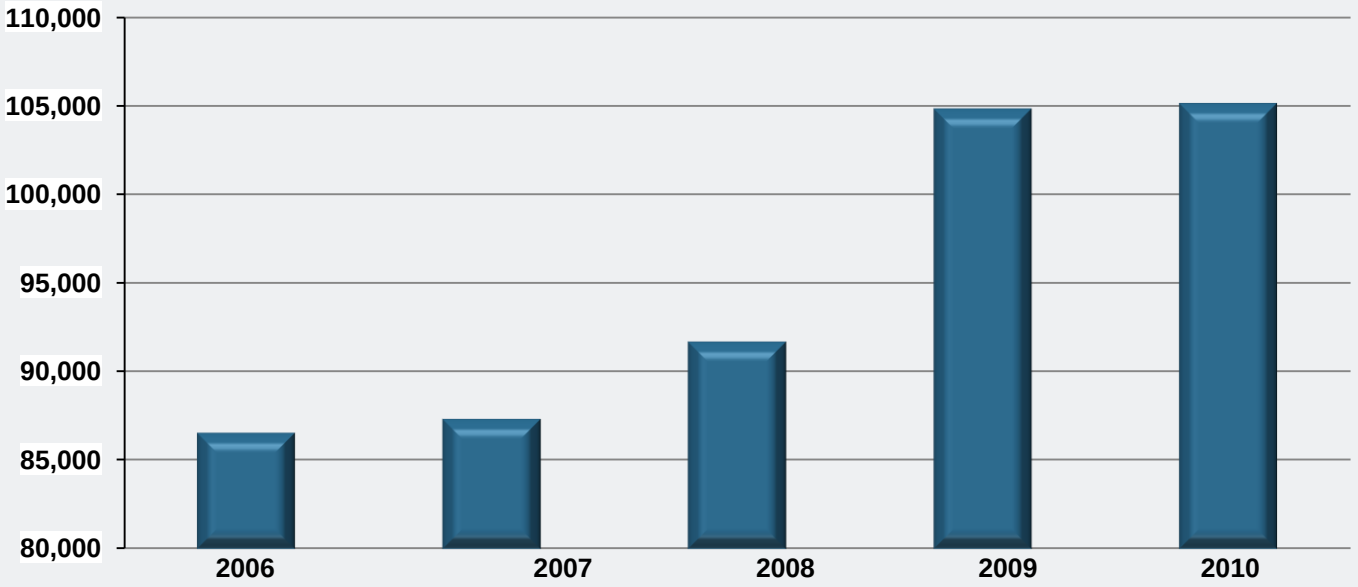
Impossible to estimate lost revenues, jobs, higher construction costs resulting from delays, not to mention delay in needed services.

Opportunities for CON Law Improvement Example: Gaston Memorial Hospital

Mount Holly Emergency Room Expansion

- Proposed in 2008
- Argued in Court of Appeals, September 2011
- CON Awarded May 2012

Emergency Room Visits
Gaston Memorial Hospital



Visits/Year	Year
86,549	2006
87,317	2007
91,661	2008
104,776	2009
105,081	2010

In short, CMHA simply has no 'right' to be free of competition, and, as a result, it is not possible that any such right has been prejudiced by the Agency's approval of the CaroMont 2010 Application.

CMHA's contested case in OAH appealing such approval…was frivolous.

CMHA's contested case in OAH appealing such approval…was filed for purposes of delay, to prevent CaroMont, the approved applicant, from moving forward with its development of a freestanding emergency department in Mount Holly.

Order Granting Motion for Recovery of Bond,
Hon. Nathanial J. Poovey, 13 July 2012

Each RME room that CaroMont developed and was unneeded would result in additional capacity for CaroMont to attempt to take away volume from CHS, at a rate of approximately 1,333 annual visits and $346,000 in annual net revenue per room.

Affidavit, CHS Consultant
20 June 2012

Annual net revenue loss = $6,228,000

Opportunities for CON Law Improvement

Eliminate outdated, unenforceable requirements.

"Diagnostic Center" means a freestanding facility, program or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds five hundred thousand dollars ($500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than five hundred thousand dollars ($500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater.

N.C.G.S. 131E-176 (7a)

Opportunities for CON Law Improvement

Make certain decisions of the State Health Coordinating Council more transparent and accountable

- All members appointed by Governor – not General Assembly
- In recent litigation, at least 22 of 29 members were recognized to be employed by or affiliated with providers regulated under the SMFP

Opportunities for CON Law Improvement

SHCC's decisions not subject to scrutiny by the Rules Review Commission.

Not subject to review on appeal.

The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms or home health offices that may be approved.

N.C.G.S. 131E-183(a)(1)

The correctness, adequacy, or appropriateness of criteria, plans, and standards shall not be an issue in a contested case hearing.

10A NCAC 14C .0402

Opportunities for CON Law Improvement

SHCC members not subject to State Ethics Act.

Table 5A: Acute Care Bed Need Projections

2010 Utilization Data from Thomson Reuters compiled by the Cecil B. Sheps Center for Health Services Research

Target Occupancy Rates: ADC 1-99: 66.7%, ADC 100-200: 71.4%, ADC > 200 and <=400: 75.2%, ADC>400: 78%

Target Occupancy Factors: ADC 1-99: 1.50, ADC 100-200: 1.40, ADC > 200 and <=400: 1.33, ADC >400: 1.28

A	B	C	D	E	F	G	H	I	J	K	L
Service Area	License Number	Facility Name	Licensed Acute Care Beds	Adjustments for CONs/ Previous Need	Thomson Reuters 2010 Acute Care Days	County Growth Rate Multiplier	4 Years Growth Using County Growth Rate (= 2010 Days, if negative growth)	2014 Projected Average Daily Census (ADC)	2014 Beds Adjusted for Target Occupancy	Projected 2014 Deficit or Surplus (surplus shows as a "-")	2014 Need Determination
Alamance	H0272	Alamance Regional Medical Center	182	0	44,987	1.0258	49,806	136	191	9	
Alamance Total			**182**	**0**							**0**
Alexander	H0274	Alexander Hospital	25	0	0		0	0	0	-25	
Alexander Total			**25**	**0**							**0**
Alleghany	H0108	Alleghany Memorial Hospital	41	0	2,503	-1.0012	2,503	7	10	-31	
Alleghany Total			**41**	**0**							**0**
Anson	H0082	Anson Community Hospital	52	0	3,330	-1.1318	3,330	9	14	-38	
Anson Total			**52**	**0**							**0**
Ashe	H0099	Ashe Memorial Hospital, Inc.	76	0	4,813	-1.0332	4,813	13	20	-56	
Ashe Total			**76**	**0**							**0**
Avery	H0037	Charles A. Cannon, Jr. Memorial Hospital	30	0	5,531	-1.0374	5,531	15	23	-7	
Avery Total			**30**	**0**							**0**
Beaufort	H0188	Beaufort County Medical Center*	120	0	9,086	-1.0494	9,086	25	37	-83	
Beaufort	H0002	Pungo District Hospital Corporation	39	0	2,004	-1.0494	2,004	5	8	-31	
Beaufort/Hyde Total			**159**	**0**							**0**
Bertie		2011 Acute Care Bed Need Determination	0	3	0	1.0134	0	0	0	-3	
Bertie	H0268	Bertie Memorial Hospital	6	0	1,540	1.0134	1,624	4	7	1	
Bertie Total			**6**	**3**							**0**
Bladen	H0154	Cape Fear Valley-Bladen County Hospital	48	0	3,219	-1.0745	3,219	9	13	-35	
Bladen Total			**48**	**0**							**0**
Brunswick	H0250	Brunswick Community Hospital	74	0	11,103	-1.0300	11,103	30	46	-28	
Brunswick	H0150	J. Arthur Dosher Memorial Hospital	36	0	3,720	-1.0300	3,720	10	15	-21	
Brunswick Total			**110**	**0**							**0**
Buncombe	H0036	Memorial Mission Hospital	673	60	184,366	1.0114	192,936	529	677	-56	
Buncombe/Graham/Madison/Yancey Total			**673**	**60**							**0**
Burke	H0062	Grace Hospital, Inc.	162	0	16,505	-1.0680	16,505	45	68	-94	
Burke	H0091	Valdese General Hospital, Inc.	131	0	8,283	-1.0680	8,283	23	34	-97	

Projections based on four-year average county-specific growth rates, compounded annually over the next four years. Acute Care Days data from 2006, 2007, 2008, 2009, 2010 were used to generate four-year growth rate.

(ADC= Average Daily Census)

Questions?

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